July 7, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1195-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor who is specialized and board certification in Anesthesiology and Pain Management. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ suffered an industrial injury to the low back region on ___ during the usual course and scope of his work for ___ . He received the diagnoses of lumbar strain and sciatica. He was originally under the care of ___. These physicians provided pain-related medications including Celebrex, Carisoprodol, Hydrocodone/ acetaminophen and physical therapy. Because of his ongoing low back pain picture, he was referred to ___ and ___. ___ has been providing lumbar epidural steroid injections and facet injections; ___ has continued his pain medications. More recently, ___ has recommended the purchase of an RS-4i sequential stimulator for pain control.

REQUESTED SERVICE

An RS-4i sequential stimulator (a 4-channel combination muscle stimulator and interferential unit) is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Interferential stimulators are a perfectly acceptable pain control device and have been in widespread use for many years. Nonetheless, ___, LVN from ___ in her note dated 4/25/03 stated quite sensibly that the documentation provided no objective evidence of efficacy. What were ___ ROM measurements prior to using the stimulator, and what are they now? What was the pain medication usage prior to using the stimulator, and how much is he taking now? What activities can he now perform that he could not prior to using the stimulator?

___ notes regarding the stimulator issue, such as his note from 3/18/03, suggest a subjective improvement in overall pain and muscle spasm after continued use of the stimulator. Were objective evidence of overall improvement to be shown as well, such as demonstrated reduction in pain medication and muscle relaxant intake, or improvement in vocational, recreational and social activities while using the device, a definitive proof of the need or the usefulness for this device would have been fulfilled. The documentation provided no objective evidence of efficacy.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of July 2003.